The Holman Group
Managed Behavioral Health Care Services

2023

Provider Manual

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The Holman Group
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The Holman Philosophy

The Holman Group is dedicated to providing the most appropriate and intensive treatment, in the least restrictive setting. We believe that this approach has a sound therapeutic foundation as well as an economic one. Through this intensive treatment approach, we strive to create, establish, and provide short-term treatment plans which promote client independence and encourage participation in community-based programs for support and maintenance.

We believe that people recover from their problems most quickly when they are treated in surroundings that most closely resemble their normal daily lives; among family, at home, at work, and at play. Helping people resolve their problems is Holman's highest priority. The Holman Group takes pride in the quality services our providers offer and looks forward to developing a mutually beneficial and satisfying working relationship.

Introduction

Welcome to The Holman Group family of health care professionals. The Holman Group's Employee Assistance Program (EAP) and Membership Aid Plan (MAP) are composed of a nationwide network of behavioral healthcare professionals who offer a comprehensive program of mental health and chemical dependency assessment, referral, and treatment services.

In addition to EAP/MAP services, The Holman Group also serves as a managed mental health/chemical dependency plan for many of its clients. As a managed care organization, we offer treatment authorization, care management, and utilization review for the following treatment modalities:

- Information and Referral Services
- Group Therapy Services
- Individual Outpatient Services
- Intensive Outpatient Therapy
- Psychological Testing
- Psychiatric Evaluation/Medication Management
- Day Treatment
- Residential Treatment
- Alcohol/Drug Rehabilitation
- Detoxification
- Hospitalization

This Provider Manual outlines those procedures which will enable you to function effectively as a Holman contracted provider. Additionally, the Provider Relations Department is available to assist you with any questions or concerns. The Provider Relations Department can be contacted by:

Phone: (818) 704-1444 (local) or (800) 321-2843 (nationwide),
Mon. – Fri. from 8 AM to 5 PM PST

Email: PR@holmangroup.com

Fax: (818) 346-3756

Below is a description of the activities and services of the various departments within The Holman Group.

The Holman Group Departments

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Department	Responsibilities	Contact Staff
Care Access Department	• Receives calls from clients requesting treatment. • Gathers demographic information. • Refers clients to individual contracted providers. • The Care Access Specialist authorizes the initial EAP/MAP and/or insurance treatment sessions, coordinates all incoming crisis calls and verifies client's eligibility to receive benefits. Records provider's diagnostic information and conveys it to the Care Manager who will authorize, if appropriate, additional EAP/MAP and/or insurance treatment sessions.	Care Access Manager, Care Access Specialists
Provider Relations Department	• Contracts with and credentials individual providers and facilities nationwide for mental health and chemical dependency treatment services. • Provides information and referral services (e.g., community resources, self-help groups and adjunctive therapies). • Responds to provider inquiries and concerns regarding Holman policies and procedures. • Provides The Holman Group forms required for use as a contracted provider. These include billing forms, client information forms, clinical assessment forms, progress notes and discharge summaries.	Provider Relations Manager; Provider Relations Specialists; and Credentialing Coordinator.
Inpatient Care Management	• Makes all treatment authorization decisions on inpatient and higher level of care cases. • Carefully monitors all inpatient and higher level of care cases (e.g., residential, day treatment, sober living, and intensive outpatient). • Maintains regular contact with provider to ensure treatment goals are met. • Coordinates and makes discharge plans from one level of care to another (i.e., hospital to residential). • Interprets and explains patient benefits to providers and patients.	Director of Clinical Services; Critical Health Care Advisor
Outpatient Care Management	• Makes all treatment authorization decisions on outpatient cases. • Carefully monitors outpatient cases including the review of clinical assessments and requests for continued authorizations (renewals). • Coordinates assignments of patients to psychiatrists. • Interprets and explains patient benefits to providers and patients.	Director of Clinical Services; Outpatient Health Care Advisor

	• Provides supervision, remediation, and education to providers when necessary.	
Compliance Department	• Oversees the patient Grievance Process. • Supervises and monitors over the Provider Dispute Resolution Committee • Monitors integration of Quality Management Plan into day-to-day operations. • Facilitates analysis of data obtained through Quality Improvement monitoring. • Interprets Provider/Client Satisfaction Survey findings in the interest of identifying areas in need of improvement.	Director of Fraud, Waste and Abuse; Compliance Manager
Utilization Review Department	• Creates and maintains patient files. • Processes requests for authorization extensions for individual treatment sessions. • Mails out all written verification of authorization to providers. • Provides the Request for Treatment Authorization (Renewal) forms to providers.	Utilization Review Specialist; Utilization Review Staff; Medical Records Staff
Claims/Accounting Department	• Reimburses providers for services rendered to Holman referred clients.	Finance Manager; Claims Coordinators
Sales and Client Services	• Maintains smooth functioning of corporate/labor accounts. • Consults with client account management/personnel on issues related to employees' mental health and job functioning. • Monitors Formal Management Referrals. • Markets The Holman Group's HMO/EAP/MAP plans to potential corporate/labor accounts.	Vice President; Sales Manager; Sales Representative; Client Services Representative
Additional Departments	• MIS (Management Information Systems) - Data processing, Web development	Administrative Support Team
You may contact each of these departments by calling (818) 704-1444 or (800) 321-2843 (nationwide) Monday through Friday from 8:00 AM to 5:00 PM (PST)		

Behavioral Health and EAP Access Availability Standards

The Holman Group has established access standards for face-to-face services as required by the Department of Managed Health Care (DMHC).

1. Providers must be able to offer a member an appointment with five (5) business days for routine cases, 48-hours for urgent cases, or within 6-hours for non-life-threatening emergent cases. All other life-threatening cases need to be directed to 911 or the nearest hospital. Providers shall cooperate and comply with the standards within the Provider Manual.

   The access standard can be changed if the referring or treating licensed care provider assesses a different standard is acceptable and within recognized standards of practice. Any deviation from the standard needs to be documented in the member's record indicating that the longer waiting time will not have an adverse effect on the member's well-being.

2. It is the provider's responsibility to be in compliance with the following standards:

a. Disclose hours of operations to clients (new and established), by including this information on a pre-recorded telephone message or any other effective and verifiable means.
b. Provide coverage for your practice when not available, including but not limited to, having an answering service with emergency contact information.
c. Inform members of how to proceed should they need services after business hours, including but not limited to, providing a pre-recorded telephone message with directions for the callers or clients to call 911 or go to nearest emergency room, in case of an emergency.
d. Inform members as to when they can expect a return call after leaving a message and to call an alternate number or 911 immediate assistance is needed.
e. Respond to telephone messages in a timely manner.

3. Providers shall inform the enrollees/members that language assistance services are available, and the services are provided to them at no charge by The Holman Group.

   In addition, providers are also responsible for the following:

   - Providers shall notify The Holman Group if a situation arises in which language assistance is needed for a limited English proficient member.
   - Providers shall notify The Holman Group within one (1) business day of any requests for translation or interpretation of vital documents.
   - Providers shall ensure that their office staff members who are in contact with members are trained to work effectively with in-person, video, and telephone interpreters.
   - Providers shall submit an attestation in regard to their availability, either themselves or an employee, to provide services in a language other than English.
   - Providers are required to submit and update any changes that have occurred to its language assistance capabilities by contacting Holman's Provider Relations Department.

4. Office appointment wait times should be less than 30 minutes after the members scheduled appointment with the provider.

Client Referrals

Initial call to Intake

The client calls the Holman Care Access Department to be assigned to a Holman Contracted Provider. A Care Access Specialist will obtain information from the client regarding the presenting problem and statistical information (i.e., name, address, phone number, client account, etc.). After verification of the client's eligibility, the Care Access Specialist contacts a Holman Contracted Provider within 15 miles and/or 30 minutes from the client's geographic area with expertise in the presenting problem(s).

Referral to Provider

When making a referral to a provider, the Care Access Specialist will:

- Call the provider with a referral or leave a message for the provider to call The Holman Group within the same business day. If the Care Access Specialist identifies the case as emergent or urgent, a return call from the provider is expected as soon as the message is received.
- Authorize services depending on various factors including Client Company, benefit schedule, etc.

- Provide the client's benefit schedule, including copayment and applicable deductible information.
- If applicable, specify a time frame in which to complete the authorized sessions (i.e., five weeks for five sessions).
- Inform the provider whether to contact the client at home or at the place of employment.
- Inform the provider of the appropriate procedures to follow after the patient is seen for the first session.

What to do after accepting a referral?

For a routine referral, once the provider accepts the case from a Care Access Specialist, the provider must call the client within twenty-four (24) business hours and make every effort to set up the initial session within five (5) business days. If the client is identified by the Care Access Specialist as being in crisis (i.e., requires access to emergent or urgent care), the provider should call The Holman Group back immediately. On-Call clinicians are available twenty-four (24) hours per day to assist clients in crisis through our toll-free nationwide phone number, (800) 321-2843.

When leaving a message for a client, never indicate that you are calling from or on behalf of The Holman Group. It is imperative to maintain confidentiality. The provider should give only their name and phone number. If the provider is unable to reach the client and/ or schedule an acceptable appointment, the provider must notify Holman's Care Access Department immediately. This allows The Holman Group to either attempt to reach the patient, and/ or make a note in the patient's file that they were unreachable after requesting initial services.

If the provider is unable to accept a case, they must immediately inform Holman's Care Access Department. Unavailability for a case will not adversely affect the provider's status as a Contracted Provider.

It is the provider's responsibility to inform the client of The Holman Group's **24-HOUR CANCELLATION POLICY***:*

A client may cancel an appointment if 24-hours advanced notice is given. Late cancellations and/ or no-shows may result in the client's loss of an authorized session. The Provider may bill The Holman Group for no-shows or late cancellations that occur during authorized EAP or free HMO/ ASO carve-out sessions. This amount shall not exceed thirty-five dollars ($35.00). A late cancellation refers to a client who fails to cancel with at least 24-hours advanced notice. The Holman Group will pay for up to two (2) no-show/ late cancellation occurrences per benefit year, per enrollee. For no-show/ late cancellations after the maximum two (2) per benefit year, the provider may charge the enrollee directly for such an event. If a copayment is required, an enrollee may be charged the applicable copayment or the sum of thirty-five dollars ($35.00). The no-show/ late cancellation policy may differ for each client company. The Care Access Specialists is available to inform providers of the applicable no-show/late cancellation policy.

Upon receiving a referral, the provider should schedule an appointment at the earliest mutually convenient time. If the earliest mutually agreed upon time is more than five (5) business days, the provider must notify Holman's Care Access Department.

What to do after seeing the client for the first session?

Following the first date seen, the provider will forward, either by fax at (818)704-4252 or mail to Holman's Care Access Department, a completed copy of the Clinical Assessment form. This form needs to be on file before applicable claims can be paid.

For those cases which allow for additional sessions and require additional treatment, the provider will complete a Request for Treatment Authorization Renewal (RTA) form and forward either by fax (818) 704-4252 or by mail to Holman's Utilization Review Department ten (10) days prior to the authorization expiration date. Holman's Health Care Advisors will review the RTA form for completeness and clinical

appropriateness. The provider will receive written notification of the treatment authorization outcome. Authorization decisions made by Health Care Advisors are based on Holman's Clinical Review Guidelines. Health Care Advisors will communicate the process used to authorize or deny services under the benefits provided by The Holman Group. Health Care Advisors will also communicate those processes to enrollees or persons designated by an enrollee upon request.

What about management referrals?

For a management referral, once the provider accepts the case from a Care Access Specialist, they are transferred to a Senior Account Executive who will provide an orientation to the case and discuss the management referral policies and procedures. The Account Manager communicates the treatment compliance information with the client's employer.

Following the first date seen, the provider will forward (either by fax at (818) 704-4252 or mail) to the Senior Account Executive completed copies of the Clinical Assessment form. This form needs to be on file before applicable claims can be reviewed for reimbursement.

If the provider feels that an additional assessment session is needed to further diagnose or recommends adjunctive, additional or a different form of therapy (i.e., medication evaluation), the provider should make those requests to the Outpatient Department. If the client is in a crisis, the provider should contact the Outpatient Department immediately to discuss the case. The Outpatient Health Care Advisor may verbally authorize additional sessions within a specific period of time, if appropriate.

It is critical that confidentiality be maintained at all times. Do not contact or release any information to any representative of the client's employer, such as supervisors or human resource personnel. The Holman Account Executive should be contacted immediately if the provider receives a call from a representative of the client's employer.

The provider will receive written authorization for all approved treatment sessions. The written authorization will confirm the verbal authorization for treatment sessions. The Health Care Advisor will note the number of sessions authorized and the time frame to complete these sessions. An RTA form may also be sent to the provider. If additional sessions are needed, please complete and return this form to Holman ten (10) days prior to the treatment authorization expiration date.

What if the client has a deductible?

There are certain clients who may have a deductible. All deductible and copayment information will be given to the provider at the time of referral. If a client disagrees with the deductible amount, then the provider should require the client to bring in an Explanation of Benefits form (EOB) from their insurance carrier to determine if any applicable deductible has been satisfied. It is the provider's responsibility to collect any outstanding deductible for authorized insurance treatment sessions.[1]

In addition to the EOB, the client must bring a signed insurance claim form obtained from their benefit department. Holman's HMO clients have no deductibles or insurance claim forms for their mental health/chemical dependency services.

[1] The deductible amount must be collected by the provider and used towards payment. The Holman Group will deduct any deductibles due from provider reimbursement.

All financial obligations, including applicable deductibles and copayments, must be discussed with the client during the first session.

If the client is unable or unwilling to meet the deductible or copayment, please call The Holman Group immediately after the initial session.

Provider Actions/ Reminders After Receiving a Referral

- Contact the client within 24-hours to set an appointment.
- Meet with the client within five (5) business days for first Holman referred session.
- Notify Holman's Care Access Department by the next business day if client was a "no-show" or "late cancellation."
- Discuss financial obligations with the client (i.e., applicable deductible and/or copayments).
- Obtain the client's signature for billing purposes.
- Obtain authorization for additional EAP/MAP and/ or insurance treatment sessions from Holman's Health Care Advisors.
- Collect a signed claim form from the client's insurance carrier, if the client is not covered by The Holman Group HMO. *Note: Holman HMO referred clients have no deductibles.*
- If applicable, receive copy of the Explanation of Benefits (EOB) as proof that the client's deductible has been fully or partially satisfied.
- Collect any outstanding deductible from the client. *Note: Providers will not be reimbursed by Holman if the client's deductible has not been satisfied.*
- Collect applicable copayments from clients. *Note: Copayments are kept by the provider and deducted from the provider's contracted rate.*
- Request additional authorized treatment sessions by completing and forwarding to Holman a Request for Treatment Authorization (RTA) ten (10) days prior to the expiration date of your current authorization.
- It is recommended that provider's establish the client's file with a copy of each form, including Clinical Assessment form, Progress Notes form, Client Information form, and Authorization for Release of Information form. All forms can be found on Holman's website; www.holmangroup.com

Reporting Adverse or Sentinel Events

The provider must report immediately any Adverse or Sentinel Events to The Holman Group. Adverse or Sentinel Events include:

- Successful and attempted suicides
- Behavior exhibiting danger to self (other than suicidal behavior)
- Behavior exhibiting danger to others
- Patient injury during the course of treatment
- Tarasoff Interventions
- Ethical/ Legal misconduct

If the provider is unsure whether an incident can be considered an Adverse or Sentinel Event, they should contact the Holman Group and confirm.

Call 1-800-321-2843 during business hours (8 AM — 5 PM PST) and speak with an Outpatient Health Care Advisor. For afterhours assistance, call 1-800-321-2843 and speak to an on-call therapist and report the incident.

Grievance Mechanism

Enclosed in your original provider packet is a copy of The Holman Group's Grievance/ Complaint Form. Please have this form available for Holman Clients that express dissatisfaction with The Holman Group or the services rendered. The grievance form is also available on our website.

By definition, a grievance from an enrollee is an oral or written expression of dissatisfaction regarding the Holman Group and/ or a provider including quality of care concerns, and shall include a complaint, dispute, request for reconsideration, or appeal made by an enrollee and/ or the enrollee's representative. The Holman Group investigates all grievances and communicates resolutions within 30-days of receipt.

Notice(s) explaining how enrollees may contact their Plan, file a complaint with their Plan, obtain assistance from the Department of Managed Healthcare and seek Independent Medical Review is available in Spanish by contacting the Holman Group (800) 321-2843 or via the website at www.holmangroup.com. This information can also be obtained through Department of Managed Healthcare website www.dmhc.ca.gov.

Filing Grievances

All enrollees will have reasonable access to file a complaint/ grievance. Complaints/ grievances may be reported to any Holman staff member in person, by telephone, or in writing.

Phone: **1-800-321-2843**

Online: **www.holmangroup.com**

Mail: **The Holman Group**
Attention: Grievance Department
P.O. Box 8011
Canoga Park, CA 91309

Email: **grievance@holmangroup.com**

If a member needs assistance with filing a grievance, Holman Client Services Personnel will assist them. Call (800) 321-2843 for assistance.

The Holman Representative will direct all complaints/ grievances to the Compliance Department for investigation.

For questions regarding the Grievance Mechanism, please contact the Provider Relations Department (800) 321-2843.

Treatment Referrals

Each client's benefit plan has specific program options and limitations. If the provider recommends a different treatment modality such as hospitalization, residential treatment, day treatment, intensive outpatient services, psychiatric services, or a medication evaluation, for a Holman referred client, the provider **MUST** contact The Holman Group's Care Management Department to request referral services.

If a Holman client has only received an assessment session from the provider, and the provider would like to recommend a different course of treatment, the provider should contact Holman's Care Access Department.

If a Holman referred client is receiving ongoing treatment from a provider, and the provider would like to recommend a different course of treatment, the provider should contact Holman's Care Management Department.

The Providers are responsible for ensuring their contact information (e.g., Telephone number, fax number, mailing address, physical location address, email, etc.) is current with The Holman Group. Additionally, the Provider Relations Department must receive, and have on file, a copy of the providers' current license and liability/ malpractice insurance information. We are unable to assign cases to any provider whose license and/ or liability/ malpractice insurance has lapsed. Please notify the Provider Relations Department in advance of any absence, vacation, or change in availability.

Phone: (818) 704-1444 (local) or (800) 321-2843 (nationwide),
Mon. – Fri. from 8 AM to 5 PM PST

Email: PR@holmangroup.com

Fax: (818) 346-3756

Behavioral Health Treatment

Behavioral Health Treatment (BHT) means professional and treatment programs, including applied behavior analysis (ABA) and other evidenced based behavior intervention program services that develop or restore, to the maximum extent practicable, the functioning of an individual with autism spectrum disorder (ASD).

Please be aware not all benefit plans provide coverage for BHT. Eligibility/coverage for BHT benefits can be verified by contacting a Holman's Care Management Department.

Authorizations

All BHT services require pre-authorization by Holman and are subject to medical necessity review.

In order for BHT to be covered/ authorized, the provider must comply with California Health and Safety Code 1340 et seq. and all applicable law and requirements therein, including but not limited to, meeting all of the following criteria:

- There must be an established DSM-5 diagnosis of Pervasive Developmental Disorder or Autism Spectrum Disorder.
- Psychological testing for the determination of the diagnosis and treatment recommendations must be requested by a licensed professional.
- Treatment is recommended after the psychological testing and determination of ASD diagnosis.
- A functional behavioral analysis (FBA) must be completed and a treatment plan prescribed by a Qualified Autism Service (QAS) provider.
- Holman will review the request and make a determination for authorized services based on the information in the FBA.
- The treatment plan must be provided under a prescribed QAS 1) provider, 2) professional supervised and employed by a QAS provider 3) paraprofessional supervised and employed by a QAS provider. The information within the treatment plan by must include and/or not limited to:
    - A description of the patient's behavioral health impairments to be treated.
    - Measurable goals (including a baseline and mastery criteria) over a specific timeline.

    - An individualized intervention plan (which utilizes evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism) that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported; and
    - A transition plan to lower level of care and/or a discharge plan to discontinue intensive behavioral intervention services when goals and objectives are achieved or no longer appropriate.
- The treatment plan should be modified and updated as needed, but no less than once every six months, to ensure the patient continues to meet criteria for services. Progress should be documented and reviewed for effectiveness of services.
- Coordination of care with providers should be clearly documented.

Supervision Requirements

- Supervision of the QAS professional or paraprofessional is on a ratio of one (1) hour of face-to-face supervision by the QAS provider for each eight (8) hours of BHT provided by QAS professional or paraprofessional.
- Supervision must occur at the treatment location with the child, QAS professional or paraprofessional, and QAS provider (supervisor) present during the delivery of BHT.
- No more than one (1) hour of supervision for each eight (8) hours of BHT will be authorized.

Credentialing Requirements for Behavioral Health Treatment Providers

Qualified Autism Service (QAS) provider means either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, or
- A person licensed pursuant to Division 2 (commencing with Section 500) of the business and Professions Code who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified (1374.43(c)(5)(C)).

Individual Qualified Autism Providers

- Licensed practitioner (Psychologist, LCSW, MFT or LPCC) with adequate experience and training in the treatment of Autism Spectrum Disorders.
- BCBA or BCBA-D with active certification and adequate experience and training in the treatment of Autism Spectrum Disorders.
- Minimum malpractice insurance of one million ($1,000,000) per occurrence/ three million ($3,000,000) aggregate.
- Services must be provided by a qualified autism service provider to the member.

Qualified Autism Agencies

- Employs a QAS provider that is a licensed clinician or a BCBA with adequate experience and training that conducts assessments, treatment plans and provides direct supervision and training of QAS professionals and paraprofessionals. QAS has evidence of a minimum two (2) years relevant work history.
- Minimum malpractice insurance of one million ($1,000,000) per occurrence / three million ($3,000,000) aggregated.

- Employs QAS professionals under the supervision of the QAS provider to conduct treatment as designed by the QAS Provider. The QAS professional as defined in Section 54342 of Title 17 of the California Code of Regulations and has training pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code. (1374.43(c)(5)(C)).
- Employs QAS paraprofessionals which are unlicensed or uncertified individuals that are supervised directly by the QAS provider and conduct treatment as designed by the QAS Provider. All QAS paraprofessionals must meet the criteria set forth in the regulations adopted pursuant to Section 4686.3/17 CCR 54342(b) of the Welfare and Institutions Code. (1374.73(c)(5).
- Services must be provided by a QAS professional and/or paraprofessional under the supervision of a BCBA or licensed clinician. Services will also include supervision hours.

It is critical that confidentiality be maintained at all times. Providers should not contact or release any information to any representatives of the client's employer, supervisor, or human resources personnel. Holman's Account Executive should be contacted immediately if the Provider receives a call from a representative of the client's employer.

Formal Management (Work Performance) Referrals

For all Formal Management referrals, the provider must have the client sign the **Authorization for Release of Information form, Formal Management Referrals section.** The provider is responsible for sending a copy to The Holman Group, attention to the Account Executive.

Mail: The Holman Group
Attention: Account Executive
P.O. Box 8011
Canoga Park, CA 91309

Email: ClientServicesRequest@holmangroup.com

Fax: (818) 346-3756

A copy of the completed form should be provided to the client. The provider will be responsible for retraining a copy for their records.

A Formal Management Referral is a referral made by the client's employer for work performance related issues. In order for The Holman Group to report the client's status to the employer, we must collect the following information from the provider:

- Client's attendance in treatment
- Client's compliance with the treatment plan
- Client's leave status, if any, from their job (pertains to authorized medical leaves)
- Client's prognosis

The Holman Group's Care Access Specialist will inform the provider of Formal Management Referrals when assigning the case(s). All communication with the client's employer will go through Holman's Account Executive.

The provider will follow the appropriate procedures after the initial assessment session unless directed otherwise by Holman's Account Executive.

If a Formal Management referred client is non-compliant or misses a session for any reason, the provider must immediately notify the Holman's Account Executive. The Provider should not contact the client's employer/ supervisor directly.

Since Formal Management Referrals may result in job actions (e.g., retention, suspension, discharge, etc.), it is important to keep current and complete records.

Summary of Utilization Management Process, Guidelines, and Criteria

Materials and resources given to Providers by The Holman Group include Holman's guidelines used to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered.

The Holman Group is committed to providing high quality mental health services and strives toward excellence in customer service. It is our desire to help the client to reduce functional impairments and to improve daily functioning. It is also our goal to deliver quality mental health services through the effective use of resources while measuring outcomes and satisfaction via continuous quality improvement methodologies.

The function of Utilization Management is to facilitate the provision of quality, efficient mental health services to clients and providers through monitoring, evaluating, and influencing the processes and behaviors, which impact the delivery of services. Managing the treatment patterns of the delivery systems for maximum efficiency is the overall goal of Utilization Management.

Accessing Services and Making Referrals

The Holman Group benefits, including higher-level of care and alterative care, require pre-authorization.

Services provided on an emergency basis do not require prior authorization. In the case of emergency treatment, it is required the provider and/ or facility contact The Holman Group upon admission.

Providers rendering outpatient services to enrollees who need to make referrals for additional services must contact The Holman Group. Services will be authorized upon review.

Authorizations Decisions: Initial and Concurrent Review

For outpatient cases:	Pre-authorization is not required. Request for Treatment Authorization (RTA) is only necessary if the provider is requesting authorization sessions exceeding the member's benefit plan.
For higher-level of cases and acute care:	Initial, concurrent, and retroactive authorization decisions are made by The Holman Group. Initial treatment authorization decisions are made at the time that the assessment and treatment plan are reviewed with the provider. Providers are verbally notified at that time of the initial authorization and will also be notified by mail in the form of a Notification of Authorization. Client treatment progress and requests for continuing treatment authorizations are reviewed concurrently. Renewal requests are reviewed by The Holman Group for client progress, the continuing presence of impairments in functioning and crisis situations, and adherence to the treatment plan.

Retroactive Reviews

Retroactive treatment authorization requests will be reviewed by The Holman Group upon receipt.

Processes and Criteria Used to Authorize or Deny Services

The clinical review guidelines utilized by the Holman Group are based on national standards for mental health professional practice. These fields include Psychiatry, Clinical Psychology, Clinical Social Work, Marriage, Family and Child Counseling, and Psychiatric Nursing.

Pursuant to SB855 California Safety Code sections 1374.721(e), subsection 2. – 3., The Holman Group utilizes a formal education program by nonprofit clinical specialty associations for clinical review criteria. Network providers are not required to participate in the education program however Holman has made available the clinical criteria at no cost upon request to providers and enrollees.

Level of Care Criteria Resources

- American Society of Addiction Medicine (ASAM)
- American Association of Community Psychiatrists - Level of Care Utilization System (LOCUS)
- American Association of Community Psychiatrists - Child and Adolescent Level of Care Utilization System (CALOCUS)
- American Academy of Child & Adolescent Psychiatry - Child and Adolescent Service Intensity Instrument (CASII)
- American Academy of Child and Adolescent Psychiatry
- World Professional Association for Transgender Health - WPATH Standards of Care

Please contact The Holman Group's Provider Relations Department for more information, training, or resources.

The clinical review guidelines define the general criteria used to determine the level of care and type of treatment needed for each case. The criteria include medical necessity, impairment of functioning, severity of risk factors, and level of care required to effectively treat the patient's problem. Authorization decisions are also influenced by the unique characteristics of each individual benefit package (which determine the available benefit), and the specific limitations of each plan.

Implicit in these guidelines is The Holman Group's goal to provide the most effective, appropriate level of care in the least restrictive (intensive) environment, and within the benefit package purchased by the client's organization/ employer. This also requires that all patients have access to the covered services they need and that they receive quality treatment.

Medical Necessity

Clinical decisions for care are made based on medical necessity.

The following conditions must be present to meet the criteria for medical necessity:

- Services are adequate and essential for the evaluation and treatment of a disease, condition, or illness, as defined by standard diagnostic nomenclatures (DSM-IV, ICD-1 0).
- Treatment can be reasonably expected to improve an individual's condition or level of functioning.

- Evaluation and treatment methods are in keeping with national standards of mental health professional practice, using methods of treatment or evaluation for which there is an adequate basis in research.
- Are provided at the most cost-effective level of care that is appropriate to the clinical needs of the patient.

To maintain authorization of benefits, all four elements of medical necessity must be present throughout the course of treatment.

Coordination of Care

The Holman Group encourages all our network providers to coordinate care with any other provider treating the enrollee.

Notification of Authorizations and Denials to Providers and Enrollees

Providers receive written notification of authorizations for all services authorized. Providers receive a written notification of authorization describing the services, number of units (sessions, days, etc.) and the time period authorized.

For enrollees receiving higher levels of care, authorizations and denials are communicated to the provider via phone and are followed by a written notification of authorization. When appropriate, these decisions are communicated to the enrollee directly by The Holman Group. If the enrollee is unavailable, the provider informs the enrollee of the authorization decision.

Initial outpatient authorization decisions are communicated verbally to the provider over the phone and are confirmed with a written notification of authorization. The Holman Group will attempt to contact the enrollee regarding the authorization decision and inform the enrollee of their assigned provider.

Denial of Authorization and Appellate Process

Benefits may be denied for a number of reasons, all of which are defined in the evidence of coverage information provided to the enrollee. Possible denials of authorization are reviewed by individual Health Care Advisors, Care Management Supervisors, or the Utilization Management Committee (UMC).

All denials for higher levels of care (acute hospitalization, partial hospitalization/day treatment or residential treatment) are reviewed by the supervisor of Inpatient Care Management with the final decision being made by The Holman Group Medical Director. Inpatient Care Management provides peer review/ consultation on cases requiring higher levels of care.

Outpatient authorization denials decisions may be made by Holman's licensed psychiatrist or by the UMC, which is chaired by a licensed psychologist. UMC reviews outpatient cases that have accumulated fifteen (15) or more sessions during the current course of treatment. UMC may also review, for the purpose of peer consultation, any difficult or challenging cases that a health care advisor presents to the committee. Outpatient authorization denials to physicians will only be made by a Holman Psychiatrist.

The following are some of the more frequent reasons that denials of authorizations are made:

- The patient meets one or more of the exclusionary criteria mentioned above (both contractual and operational).
- The patient does not meet inclusionary criteria.
- Treatment at the requested level of care is not justified as medically necessary.

- There has been an improvement in functional impairment, severity of illness and risk factors such that the patient does not require treatment at the requested level of care.
- There has been an improvement in functional impairment such that the patient can resume a reasonable level of functioning in most areas of his/her life, maintaining ongoing support through community resources.
- The treatment plan indicated is not appropriate to the treatment of the original problem(s) identified, or is not indicative of solution-focused, brief therapy.
- Following an adequate period of treatment, it does not appear that further treatment will produce significant improvement in the level of functional impairment.
- The patient is repeatedly non-compliant with one or more aspects of the treatment plan, thus impairing the progress and stability of treatment.
- The patient's benefit is exhausted.

Disclosure to Providers and Enrollees of Criteria Used Justifying Treatment Authorization Decisions

All denial decisions are communicated to the provider, either verbally or in writing, at the time of the decision. Criteria supporting specific authorization decisions will be disclosed, upon request, to both the enrollee and the provider by Holman's Health Care Advisor. To inquire about authorization decisions, the enrollee or provider should contact The Holman Group's Health Care Advisor or Manager requesting justification for the decision.

Appeals to Authorization Decisions — Outpatient Care Management

Any provider, patient, or subscriber has the right to appeal a care management authorization decision. The request may be made verbally or in writing, although it is strongly suggested that verbal requests be followed by a written request documenting the petitioner's justification for appeal. Depending on the level at which the original decision was made, the following is the hierarchy of review:

- Outpatient Health Care Advisor
- Outpatient Senior Health Care Advisor
- Utilization Management Committee
- Utilization Management Committee with consultation of staff psychiatrist

Available documentation will be reviewed; additional documentation from the provider may be required. A decision regarding the appeal will be made within five working days of the receipt of all requested documentation; the petitioner will be notified in writing of the appeals decision.

Appeals to Authorization Denials — Higher Levels of Care

The process for appeals reviews of inpatient/ higher levels of care (all levels of care other than Outpatient Expanded and Intensive) will be reviewed by the Inpatient Care Management Department and the final decision is made by The Holman Group's Medical Director. This review is initiated verbally or in writing by the Facility's attending psychiatrist. This is forwarded to the Inpatient Care Manager who may require that patient records and documents be submitted for review. The appeal process will begin once the patient's records and documents are received by Holman.

The case in question is submitted to the Inpatient Care Management Department along with a request for medical review and subsequently will be forwarded to the Medical Director for final determination. Once the final decision has been made, Holman will inform the facility in writing.

If a satisfactory decision is not reached, the option of a second appeal by an outside board-certified psychiatrist may be requested. A complete copy of the patient's record along with a cover letter from the facility should be submitted to The Holman Group. The decisions made at this level of appeal shall be considered final. The facility/ psychiatrist will be notified in writing of this decision.

A complete copy of the appeals policy and procedure can be made available upon request.

To Bill for Authorized EAP/ MAP Sessions

Please review this section carefully to facilitate the billing process.

Submit billing for dates of service for authorized EAP/ MAP treatment sessions on a universal billing form. It is essential that all information requested be complete including employee and/or client data.

Providers are to bill on a timely basis. Claims received beyond ninety (90) days after date(s) of service may not be considered for reimbursement.

All billing is between The Holman Group and the provider. Do not ask the client to contact The Holman Group regarding billing procedures.

Do not bill the client or the insurance carrier for services rendered.

Authorized EAP/ MAP sessions and authorized insurance treatment sessions are billed on a universal billing form. Providers must submit the following completed claim forms to The Holman Group, attention Claims Department:

- Universal Billing form (HCFA1500/CMS1500 or CMS1450/UB04)
- Signed Authorization for Release of Information form or indicate signature on file.

Incomplete and/or inaccurate forms will be returned and/ or denied.

A Clinical Assessment Form must be on file with The Holman Group for any claims to be reviewed for reimbursement consideration.

The Holman Group must have on file copies of the provider's current licensure and liability coverage to process claims and reimburse providers.

All services must be pre-authorized, no walk-in clients. Clients with benefits through The Holman Group should be encouraged to access their EAP/ MAP program by contacting Holman's Care Access Department. Unauthorized services will not be reimbursed.

The Holman Group will not reimburse a provider for double sessions or more than one session on the same date unless specifically pre-authorized.

No-Show/ Late Cancellation

The Provider may bill The Holman Group for no-shows or late cancellations that occur during authorized EAP or free HMO/ ASO carve-out sessions. This amount shall not exceed thirty-five dollars ($35.00).

A late cancellation refers to a client who fails to cancel with at least 24-hours advanced notice. The Holman Group will pay for up to two (2) no-show/late cancellation occurrences per benefit year, per enrollee.

Billing for Authorized Insurance Treatment Sessions

Providers must submit billing for authorized HMO treatment dates of service(s) on a HCFA or a universal billing form. It is essential that all information be complete including employee and/ or patient data.

Claims received beyond ninety (90) days after date(s) of service may not be considered for reimbursement.

For reimbursement for authorized HMO treatment sessions, submit the following forms to The Holman Group, attention Claims Department:

- Universal Billing Form (HCFA1500/CMS1500 or CMS1450/UB04).
- Signed Authorization for Release of Information form or indicate signature on file.

A Clinical Assessment Form must be on file with The Holman Group for any claims to be reviewed for reimbursement consideration.

California law provides that enrollees are not liable for any amount owed by Holman to any contracted provider in the event that Holman does not pay for pre-authorized services and that no provider may take legal action against an enrollee to collect sums owed by Holman (the Plan).

Checklist for Billing Procedures

To avoid delays in reimbursement for EAP/MAP services rendered to authorize Holman referred clients:

- The Provider should ensure that their **current licensure and liability coverage** with expiration dates is on file with The Holman Group. The Holman Group will be unable to reimburse claims or assign cases without this information.
- Complete the **Universal Billing Form (HCFA1500/CMS1500 or CMS1450/UB04)** for the client's sessions.
- Bill only authorized EAP/MAP sessions. Dates of service must occur within the authorized time period. Do not exceed the number of authorized sessions in a particular authorized time period.
- Bill only for authorized client(s).
- Make sure the client (or legal guardian) signs and dates the **Authorization for Release of Information form.**

Submit the above-mentioned forms in a timely manner to:

The Holman Group
Attention: Claims Department
P.O. BOX 8011, Canoga, CA 91309

For claims review and/ or reimbursement for insurance treatment sessions rendered to authorize Holman referred clients:

- Complete the Universal Billing Form (HCFA1500/CMS1500 or CMS1450/UB04).
- Bill for authorized client(s) and dates of service only.
- Make sure the client (or legal guardian) signs and dates the Authorization for Release of Information form if client had not done so already during their EAP/MAP session(s).
- Collect from the client any applicable deductible.
    - Obtain an EOB from the client's insurance carrier to verify if the client's deductible, or a portion thereof, has been satisfied.

- Collect and keep copayments and deductibles.

Submit the above-mentioned forms, if applicable, in a timely manner to:

The Holman Group
Attention: Claims Department
P.O. BOX 8011, Canoga, CA 91309

Copayments

It is the responsibility of the provider to collect applicable copayments from the client. Copayments are payable to the provider and are deducted from the contracted rates. The provider will not be reimbursed for uncollected copayments.

In the event that the applicable copayment exceeds the provider's contracted rate, the provider must remit the copayment in full to The Holman Group. The Holman Group will then reimburse the provider at their contracted rate.

Reimbursement Schedule

All bills must be submitted in a timely manner. EAP/ MAP and HMO provider claims are stamped when received by the Claims Department and will be reimbursed to the service provider within thirty (30) working days or within the time-frame specified by agreement or by law.

UR provider billings are forwarded by The Holman Group to the client's primary insurance carrier for reimbursement. After payment is received by The Holman Group from the insurance carrier, The Holman Group will reimburse the provider for billed authorized services at the provider's contracted rate less any applicable copayments. Outstanding deductibles must be satisfied before the provider will be reimbursed for authorized and rendered insurance treatment sessions.

EAP/ MAP and Holman HMO provider billings will be paid by The Holman Group within thirty (30) working days following receipt of any acceptable, undisputed claim form. Outstanding copayments will be deducted from the provider's contracted rate.

To avoid delays in reimbursement, the Provider should ensure that billing materials are filled out accurately. The insured's name, social security number, ID#, and employer must be clearly identified on the Billing Forms as well as required client data/ information.

Fraud Investigation

If a Provider knows or suspects illegal or wrongful billing practices by an Enrollee or a Provider, the Provider should notify The Holman Group immediately. Any information provided will be treated with strict confidentiality.

Phone: **1-800-321-2843**

Mail: **The Holman Group**
Attention: Compliance Department
P.O. Box 8011
Canoga Park, CA 91309

Email: **compliance@holmangroup.com**

Quality Management Program

The Holman Group is committed to providing quality care to its enrollees. As a member of The Holman Group's provider network, each provider is an integral part of the Quality Management Program and is expected to participate in quality improvement activities. These activities may include, but are not limited to the following:

- Evaluation of quality of care
- Clinical assessment and treatment plan reviews
- Chart audits
- Complaint/ grievance reviews
- Site visits (where applicable)
- Credentialing and recredentialing reviews
- Quality improvement studies
- Outcomes of care through:
- Discharge summary reviews
- Client satisfaction surveys
- Specific outcome studies
- Administrative procedures
- Review of compliance with program credentialing, quality, and utilization standards
- Adherence to service standards, e.g., client access to care
- Review of compliance with Holman policies and procedures

The Holman Group believes that communication between individual providers and the organization will enhance the quality of the service to clients. Therefore, providers are encouraged to share their comments and suggestions regarding ways to improve the delivery of care either in writing or by calling Holman's Provider Relations Department.

Credentialing

All providers are required to participate in the credentialing process. Providers will need to complete Holman's Provider Application and/or CAQH process.

The following documents are required to be submitted or on file with CAQH for credentialing purposes:

- Copies of license(s)
- Copies of certifications
- Evidence of malpractice insurance
- Resume
- Taxpayer identification (W9) form
- Afterhours access information
- Language Capability Attestation (Disclosure)

The completed application file is reviewed by the Peer Review and Credentialing Committee (PRCC) which makes the final determination for inclusion into Holman's provider network. A site visit may be conducted, if applicable. Once an applicant has been approved by the Peer Review Credentialing Committee, the Provider Relations Department will send the provider contracts to be signed by both parties.

Re-Credentialing

Recredentialing occurs every three years and includes a review and update of provider documents as well as a review of the provider's experience with The Holman Group. Providers are required to submit current copies of their licenses and malpractice insurance coverage to continue to participate in Holman's provider network.

Holman's Peer Review and Credentialing Committee (PRCC) will review the following in its recredentialing evaluation process:

- Chart audit results
- Clinical and administrative Provider Evaluation forms
- Client satisfaction surveys
- Salutary comments
- Complaints/grievances
- Updated credentialing information
- Site visit results (as applicable)
- Afterhours access information

Provider Credentialing and Re-Credentialing Timeliness Standards

Credentialing	• The Provider Relations Department is responsible for notifying the provider/ applicant within seven (7) business days of receiving the application to verify receipt and inform the applicant whether the application is complete. • The Peer Review and Credentialing Committee (PRCC) application/ credentialing decisions are required to be made within sixty (60) calendar days from the application completion date. *[Pursuant to AB 2581 (Salas, Ch. 533, Stats. 2022) Health care coverage: mental health and substance use disorders: provider credentials Codified in Health & Safety Code § 1374.197; Requires plans, on or after January 1, 2023, who credential health care providers for mental health and substance use disorder services for its networks to assess and verify the qualifications of a health care provider within 60 days after receiving a completed provider credentialing application. Requires plans to notify the applicant within seven business days of receiving the application to verify receipt and inform the applicant whether the application is complete.]*
Re-Credentialing	• Occurs every thirty-six (36) months. • Providers must submit a complete re-credentialing application and required documentation within ninety (90) days from the date of receipt. Holman will inactivate the Provider within the Holman's system of record if the re-credentialing application and required documentation is not submitted timely. ○ Note: If a Provider status is changed to "inactive" their cases will be reassigned to another Provider.

Provider Rights

If any information obtained during the credentialing process varies substantially from information received from the provider, the Provider Relations staff will contact the provider to notify them of any

discrepancies within seven (7) business days. The provider has the right to review all information submitted and to request the status of their credentialing/ re-credentialing application. The provider will have two (2) weeks to contact the Provider Relations Department to request a review of the material in question.

The provider will remit to the Provider Relations Department, in writing or by fax, any changes or corrections within two (2) weeks from the time the provider was presented with the material in question. Receipt of the changes or corrections will be noted in the provider file.

Provider Updates

In addition to participating in the credentialing and recredentialing processes, providers are required to notify The Holman Group's Provider Relations Department when changes occur in any of the following:

- Licensure
- Certification(s)
- Malpractice coverage
- Malpractice actions
- Hospital privileges
- Address(es) and/or phone number(s)
- Tax identification number
- Language Capability Attestation (Disclosure)
- Accessibility or Access to Care

Chart Audits

As part of The Holman Group's ongoing quality improvement procedures, and as regulated by the Department of Managed Health Care, random chart audits will be conducted and providers' compliance is mandatory. During this process, The Homan Group will randomly select a patient's file to review. If any additional information is needed, the reviewer will contact the provider. Failure to comply may result in the provider being placed on a "Hold" status and/ or may lead to termination. The Holman Group has forms and guidelines available on our website to aid the provider with meeting Chart Audit compliance standards (refer to "The Clinical Assessment Form").

The Quality Management Department has adopted standards for chart documentation which are aligned with regulatory and accreditation entities. This review will ensure that all essential components of the client's chart are present, and that overall documentation standards are met.

All forms and documentation should be thorough, legible, labeled with the client's name, dated, and signed by the provider. All forms submitted, such as Client Information or the Initial Clinical Assessment forms, should be complete with "N/A" indicated when the item is not applicable for the patient. The state of California requires a listing of the patient's primary care physician, the date of the last medical examination, and a listing of the prescribed medications with the dosage, frequency, and name of the prescribing physician. Our expectation is that each chart submitted will contain the following:

Psychotherapist

Background Information	Relevant medical, mental health, substance abuse, and treatment histories; presenting problems, risks, and symptoms; and a bio-psychosocial history, which includes a regard for the cultural/ religious background of the client; and current or past stressors affecting the patient's current functioning.
Diagnostic Information	A completed Mental Status Examination; and documented DSM-IV (all Axes) or ICD.9, which shows consistency with the listed symptoms.
Treatment Plan	Goals and measurable objectives which are concordant with the presenting problems and symptoms; an outline of the level of care, number of sessions anticipated, and duration of treatment; adaptation of the plan in accordance with the patient's strengths and weaknesses; interventions used as well as the patient's response to treatment; and documentation of appropriate referrals.
Termination Procedures	If the patient has been terminated from treatment, the reason for the termination, and a completed Discharge Summary.
Record Keeping and Documentation	Dates of contact with the patient and the patient's signature in the appropriate places (Release of Information, Treatment Plan, etc.).
Note: Process/ progress notes need not be submitted, but much of the information requested may be provided through a combination of forms (e.g., Clinical Summary, Intake information, Clinical Assessment, Request for Treatment Authorization, Discharge Summary, etc.)	

Physicians

Background Information	Relevant medical, mental health, substance abuse, and treatment histories; presenting problems and symptoms; and current or past stressors affecting the patient's current functioning.
Diagnostic Information	A completed Mental Status Examination; and documented DSM-IV (all Axes) or ICD.9, which shows consistency with the listed symptoms.
Treatment Plan	Documentation of medications prescribed, including dosage and frequency; allergies to medications; and interventions which are concordant with the presenting symptoms and diagnosis.
Referrals	Documentation of appropriate referrals.
Record Keeping and Documentation	Dates of contact with the patient; your signature on the records; evidence of informed consent for medication; and the patient's signature in the appropriate places (Release of Information, Treatment Plan, Informed Consent, etc.)
Note: Process/ progress notes need not be submitted, but much of the information requested may be provided through a combination of forms (e.g., Clinical Summary, Intake information, Clinical Assessment, Request for Treatment Authorization, Discharge Summary, etc.	

Enrollee's Right to Amend File

Any adult patient has the right to submit a written addendum to be included in their patient file/ record regarding any item or statement in the file/ record which the patient believes to be incomplete or

incorrect. The addendum must be limited to 250 words per alleged incomplete or incorrect item in the patient's record and must clearly indicate in writing that the patient wants the addendum made a part of their patient file. The provider must then attach the addendum to the patient's records and must include that addendum whenever the health care provider makes a disclosure of the file to any party.

Inquiry and Review

The Holman Group is committed to developing and maintaining a quality provider network. The Quality Management Program is responsible for identifying, reviewing and acting upon serious administrative and/ or quality of care issues regarding a provider's performance. Such concerns can be identified through:

- Client complaints/ grievances
- Client satisfaction surveys
- Quality Improvement activities (e.g., chart audits, site visits, Provider Evaluations)
- Referral and treatment review
- Credentialing and recredentialing activities
- Regulatory, professional, or legal entities (e.g., state licensing boards)

In an instance where there is a specific concern about a provider regarding a quality-of-care issue and/ or a serious administrative infraction, the Provider Relations Department will contact the provider, either by telephone or in writing, to discuss the matter and request clarifying information. Many cases can be resolved at this point. Those issues requiring additional investigation and follow-up are referred to the Peer Review and Credentialing Committee (PRCC) for review. The provider is expected to participate fully in the resolution process as a condition of continued participation in the provider network.

A resolution plan is developed which can range from (1) additional telephone remediation, (2) a site visit, or (3) a change in the provider's network participation status, including termination. The provider is notified in writing, with an explanation of the appeals process, of any action taken regarding a change in their network status.

Termination of Contractual Agreement

To terminate a contract, a provider must give sixty (60) days prior written notice to the Provider Relations Department. Please refer to the clause in the provider contract for termination agreements.

Any clients who were assigned to the provider on or before the date of termination must be handled under the terms of the original agreement. When reassignment is indicated, a Holman Care Manager will review all active cases with the terminating provider and work to ensure there's a smooth transition for the patient(s) and continuity of care. It is expected that the resigning therapist will work in a professional manner with The Holman Group and the new provider throughout the transition period.

Critical Incident Stress Debriefing (CISD/ CISM)

The CISD/ CISM program is a special group counseling plan to help police officers, paramedics, emergency medical technicians, emergency service personnel, bank personnel, and others to deal with excessive distress caused by traumatic incidents. This program provides licensed counselors who are available 24-hours a day, seven (7) days a week to meet with employees on site or in the counselor's office to help the employees debrief and destress following a traumatic incident.

Accepting an Onsite Assignment:

- Verify that the contact persons' name and phone number.
- Verify correct address to the on-site location.
- Verify times and dates for services/ expected arrival.
- Consult with Holman's Account Executive for any additional information that may assist in rendering services.

Preparing for an On-Site

Business Attire Required	Men should wear a suit with matching coat and pants, appropriate shirt, and tie. Women should wear matching jacket with skirt or pants and appropriate top.
Relaxed Professional	Men should wear suite pants, with appropriate shirt and either a sweater or tie and sport coat. Women should wear dress skirt or dress pants with appropriate top or sweater.
Punctuality and Time	It is very important for the intervention to start on time. Allow enough time to get to an on-site location, park, advance through office security measures, and meet the contact person upon arrival. The Provider should contact The Holman Group immediately at **(800) 321-2843 to speak with Holman's Account Executive** if they anticipate being late or unable to be on-site at the schedule date/ time. If the provider is asked to remain at an on-site location past the scheduled time, please notify The Holman Group and identify the person requesting the extended stay.
Communication	It is important that the provider communicates to The Holman Group any changes in their availability, or any schedule changes requested by the account representative as soon as possible. The Provider should contact The Holman Group via phone at (800) 321-2843 and speak with a Client Services Representative or an Account Executive.

Suicide/ Homicide/ Detoxification Checklist

- Detoxification Checklist
- Homicidal Intent Checklist
- Suicidal Intent Checklist
- Holman Acute Hospitalization Protocol
- Suicide/Homicide Assessment Guidelines
- Indicators of Dangerousness to Self
- Indicators of Dangerous Toward Others

Disputes Resolution Mechanism for Non-Clinical Issues

If a provider has a dispute regarding non-clinical issues (e.g., claims, contractual, credentialing, termination), they may submit the issue by phone, email, mail, or fax.

Phone: **1-800-321-2843**

Online: **www.holmangroup.com**

Mail: **The Holman Group**
Attention: Compliance Department
P.O. Box 8011
Canoga Park, CA 91309

Email: **compliance@holmangroup.com**

Disputes must contain (at minimum) the following information when being submitted to The Holman Group for review:

Provider Information	• Provider's name, • Provider's contact information (phone number, email, and mailing address)
Dispute/ Issue	• A clear identification and/or written documentation of the disputed item.
For Claims Related Disputes/ Issues	Disputes regarding a claim must be submitted within 365-days from the action that led to dispute. • Member/ Enrollee Information (name, ID#, and DOB) • Original claim number • The date(s) of service • A clear explanation of the basis upon which the provider is disputing. • Medical Records (if applicable)
For Other Issues	• A clear explanation of the issue and the reason for dispute.
Dispute Involving an Enrollee	• Member/ Enrollee Information (name, ID#, and DOB) • A clear explanation of the dispute item(s). • The date(s) of service • Member/ Enrollee's written authorization
The Holman Group will acknowledge receipt of the disputes within fifteen (15) working days. A written determination will be rendered within forty-five (45) working days of receipt of the dispute.	

Glossary of Terms

Acute Care: Short-term hospitalization for detoxification and/or psychiatric stabilization when a client presents an imminent danger to self, others, or is gravely disabled.

Applied Behavioral Analysis (ABA): the design implementation and evaluation of environmental medications to produce socially significant improvement in human behavior.

Behavioral Health Treatment: Professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

Care Management: Individual ongoing review of treatment. The Care Manager will work closely with the provider to assure coordination of all treatment.

C.I.S.D. / C.I.S.M.: Critical Incident Stress Debriefing / Critical Incident Stress Management. A special program provided for certain clients including emergency service workers and bank personnel. (For more information see CISD/CISM Section of this manual.)

Client: The insured and/or covered dependent.

Coordination Care For: To Coordinate Care with other Health Care Practitioners.

EAP (Employee Assistance Program): A program provided directly by the employer for its employees to provide assessment, referral and short-term counseling where necessary. EAPs address problems that affect work performance such as substance abuse, family and relationship problems and crisis issues.

EAP Session: An authorized session that is used for assessment and/or short-term therapy and is generally free to the client.

Emergent: Indicating emergency care, that is, a client is provided an appointment within six hours of triage decision.

EPO (Exclusive Provider Organization): A network of providers who have contracted with a health care organization to render treatment services on a fee-for-service basis to eligible employees and their covered dependents. EPO contracted providers receive client referrals from the contracting organization.

Formal Management Referral: Recommendation by patient's employer (usually his/her manager) for assessment and treatment of client for behavioral problems that interfere with client's attendance and/or productivity at work. Employee will be asked to sign a limited release of information form during the first session to allow the Holman Account Manager to be appraised of the employee's participation in treatment.

Grievance Committee: A committee comprised of at least one member from each of the Holman Departments. This committee meets as needed to discuss complaints filed by a client or a client representative.

Halfway House/Group Home: Alternative living situations which provide clients with a sober or safe environment while attending work or school. Participation in community-based support groups is

expected. The client may also participate in outpatient, day treatment or partial hospitalization programs.

HMO (Health Maintenance Organization): A prepaid health plan purchased by an employer for its employees and their covered dependents. HMO clients are only referred to HMO contracted providers.

Holman Account: A corporation or labor union that has purchased an EAP/MAP/HMO for its employees.

Insurance Treatment Session: An authorized session that is used for ongoing treatment and is charged to insurance. Deductibles and copayments may apply.

Language Assistance Program (LAP): Enrollee/ members are able to request language assistance services upon request at no charge.

MAP (Membership Assistance Program): An EAP for labor union accounts.

Partial Hospitalization/Day Treatment: Treatment in either an acute or sub-acute setting in which the client participates in the full range of programming but does not remain overnight. Such programs are usually between six and twelve hours in length and meet several times per week.

Provider: A person licensed as a psychiatrist, psychologist, clinical social worker, marriage and family therapist, nurse, other licensed health care professional or qualified autism service provider, professional or paraprofessional with appropriate training and experience in behavioral health services, working individually or within a corporation, clinic, or group practice, who is employed or under contract with Holman to deliver behavioral health services to enrollees.

Qualified Autism Service Provider: A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, or a person licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified (1374.73(c)(3)).

Qualified Autism Service Professional: An individual who provides behavioral health treatment, is employed and supervised by a qualified autism service provider, provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider, is a behavioral service provider approved as a vendor by a California regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Program, and has training and experience in providing services for PDD/A, as specified.

Qualified Autism Service Paraprofessional: An unlicensed and uncertified individual who is supervised and employed by a qualified autism service provider, provides treatment and implements services pursuant to a treatment plan, meets the criteria set forth in regulations, as specified, and has adequate education, training and experience, as certified by a qualified autism service provider, as stated under Section 54342 of Title 17 of the California Code.

Quality Management: Program designed to assess the overall quality of service delivered to patients and client organizations. Managed by committee which meets at least quarterly.

Residential Care: Sub-acute, inpatient treatment usually based on a non-medical model.

Resourcing: Searching for treatment options, community based, for a specific need. Contact Provider Relations Department.

Self-Help Group: Peer-based program of recovery from addictive and/or psychological behaviors often based on a twelve-step model.

12-Step: Spiritual/peer-based program of recovery from addictive behaviors/emotional problems (AA: Alcoholics Anonymous, NA: Narcotics Anonymous, CA: Cocaine Anonymous, ALANON for significant others of alcoholics, etc., GA: Gamblers Anonymous).

Urgent: Indicating urgent care, that is, a client is provided an appointment within 48 business hours of triage decision.

Forms

The following section provides an explanation for each Holman form.

Authorization for Release of Information Form	This form is found on the reverse side of the EAP/MAP and Holman's Insurance Billing forms. This form must be completed and signed by the client during his/her first session. If the client is a Formal Management Referral (see Page 18, Section titled "Formal Management Referrals"), he/she must complete and sign the bottom of the form as well.
Clinical Assessment Form	This form must be completed in full for all Holman clients. Send or fax at (818) 704-4252 the signed and dated copy to The Holman Group immediately following the first date seen. Keep the original for your records.
Client Information Form	This form must be completed in full for all Holman clients. Send or fax at (818) 704-4252 the signed and dated copy to The Holman Group immediately following the first date seen. Keep the original for your records.
Coordination of Care Form	This form is used to coordinate care with other Health Care Practitioners. This form gives the provider consent to release confidential Information to any other provider treating the patient.
Request for Treatment Authorization (Renewal) Form	If you feel that the client needs additional treatment session(s) beyond the initial treatment sessions authorized, you must complete this form and submit it to our Utilization Review Department for review by Care Management.
EAP Billing Form	This form is used to bill all authorized EAP/MAP sessions.
Language Capability Attestation (Disclosure) Form	This form is used for providers to report language capabilities by self or office staff.
Insurance Billing Form	This form is used to bill all sessions beyond the client's free EAP/MAP sessions. This form will come to you along with the initial "Request for Treatment Authorization" form.
Progress Notes Form	This form should contain significant data regarding progress toward stated treatment goals, significant observations about appearance and/or behaviors, documented attendance at support groups and any changes in the treatment plan. Notes must be dated and signed. A note should be made for each session. These records must be maintained in the client's file.
Discharge Summary Form	This form is used for termination of treatment. This form should be completed at the termination of treatment. If two or more months have elapsed since the client was seen for a session, the case should be considered closed unless part of an approved treatment plan. Please retain the original form in your chart and forward a copy to The Holman Group, Attention: Utilization Review Department.
Grievance Form	This form is for the client to use to file a formal grievance. This form is in your Holman HMO, EPO and PLHSO contracts. Additional forms are available by contacting our Provider Relations Department.
Client Contact Record form	Clinical records **MUST** be maintained for seven (7) years. All laws, regulations and ethics governing confidentiality and release of information apply. Any provider who violates confidentiality laws, regulations or professional ethics will be subject to immediate contractual termination.